RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LTC00722	A. BUILDING: _____ B. WING _____	12/31/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE AT WATERMAN LAKE	715 PUTNAM PIKE GREENVILLE, RI 02828

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M 0	INITIAL COMMENTS The annual State licensure and a complaint investigation survey were conducted at this facility. The Village at Waterman Lake Nursing facility is not in compliance with the Rules & Regulations for Licensing of Nursing Facilities (R23 17-NR).	M 0	The Filing of this plan of Correction (POC) does not constitute that the deficiencies alleged did in fact exist; rather this POC is filed as evidence of the community's continuing commitment to high quality resident care in full compliance with State regulations.	
M 190	PERSONNEL 1.14.1.A. Criminal Records Check 1.14.1.A. Criminal record review requirements are pursuant to R.I. Gen. Laws § 23-17-34. This Requirement is not met as evidenced by: Based on record review and staff interview it has been determined that the facility failed to provide evidence that criminal background check was obtained, including fingerprints submitted to the Federal Bureau Investigation by the bureau of criminal identification of the Department of the Attorney General, prior to or within one week of employment for 5 of 9 staff reviewed, Staff ID's A, B, C, D, and E. Findings are as follows: Per Title 23 Health and Safety Chapter 17 Licensing of Healthcare Facilities R.I. Gen. Laws § 23-17-34 states in part, "(a) Any person seeking employment in a nursing facility...which is or is required to be licensed, registered or certified with the department of health if that employment involves routine contact with a patient or resident without the presence of other employees, shall undergo a national criminal record check which shall include fingerprints submitted to the Federal Bureau of	M 190	MR 5/5/22	

Facilities Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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M 190	Continued From page 1 Investigation (FBI) by the bureau of criminal identification of the department of attorney general. The national criminal records check shall be initiated prior to or within one week of employment... (e)...The employer shall maintain on file, subject to inspection by the department of health, evidence that national criminal records checks have been initiated on all employees seeking employment on or after October 1, 2014, and the results of those checks..." 1) Record review for Nursing Assistant (NA) Staff A, revealed a hire date of 10/5/2021. Further record review revealed that a criminal background check was not obtained until 11/9/2021, which was not prior to or within one week of employment as required. Additionally, record review revealed she began providing direct patient care at the facility on 10/12/2021 and continued to work an additional 28 shifts prior to obtaining the required criminal background check. 2) Record review for Nurse Staff B, revealed a hire date of 10/15/2021. Further record review revealed that a criminal background check was not obtained until 11/3/2021, which was not prior to or within one week of employment as required. Additionally, record review revealed she began providing direct patient care at the facility on 10/16/2021 and continued to work an additional 4 shifts prior to obtaining the required criminal background check. 3) Record review for Nurse Staff C, revealed a hire date of 12/13/2021. Further record review revealed that a criminal background check has not been obtained as of this survey. Additionally,	M 190	M 190 1-5. Corrective action includes the assignment of a designated individual, HR Specialist, ("HRS") to be responsible for the collection and filing of BCI's and in turn responsible for greenlighting the official start date based on the return of the background check. While an employee may begin training, if by the seventh day the BCI has not been returned, the individual will not be permitted to work. A procedure has been instituted whereby the HRS will communicate out by email to the Administrator, Director of Nursing, and the COO, on the fifth day alerting them that the individual is approaching the seventh day post start date, so that the employee can be reminded and, if necessary, removed from the schedule on the seventh day. This procedure went into effect on Wednesday, January 19, 2022.	1-20-22

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M 190	Continued From page 2 record review revealed she began providing direct patient care at the facility on 12/21/2021 and has continued to work an additional 3 shifts without obtaining the required criminal background check. 4) Record review for NA Staff D, revealed a hire date of 10/5/2021. Further record review revealed that a criminal background check was not obtained until 10/13/2021, which was not prior to or within one week of employment as required. Additionally, record review revealed she began providing direct patient care at the facility on 10/8/2021 and continued to work one more additional shift prior to obtaining the required criminal background check. 5) Record review for NA Staff E, revealed a hire date of 10/15/2021. Further record review revealed that a criminal background check was not obtained until 11/10/2021, which was not prior to or within one week of employment as required. Additionally, record review revealed she began providing direct patient care at the facility on 10/25/2021 and continued to work one more additional shift prior to obtaining the required criminal background check. During an interview with the Administrator on 12/30/2021 at 1:15 PM, she was unable to provide evidence that criminal background checks above were completed prior to or within one week of employment as required.	M 190		
M 215	PERSONNEL 1.14.4.B. Employee Immunization & Screening 1.14.4.B. Nursing Facilities are required to obtain evidence of immunity for all health care workers	M 215		

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M 215	Continued From page 3 in accordance with the rules and regulations Pertaining to Immunization, Testing, and Health Screening for Health Care Workers (Part 20-15-7 of this Title) promulgated by the Department of Health. This Requirement is not met as evidenced by: Based on record review and staff interview it has been determined that the facility failed to obtain evidence of immunity for all health care workers in accordance with the rules and regulations Pertaining to Immunization, Testing, and Health Screening for Health Care Workers (Part 20-15-7 of this Title) promulgated by the Department of Health for 8 of 9 sample staff reviewed, Staff ID's A, B, C, D, E, F, G, and H. Findings are as follows: Per the Rules and Regulations Pertaining to Immunization, Testing, and Health Screening for Health Care Workers (R20-15-7) which states in part: "7.6.1 Immunization and Testing Requirements A. In accordance with the guidelines set forth in § 7.3(C) of this Part of these Regulations, evidence of immunity is required for all health care workers (except for health care workers who receive a medical exemption) against: 1. Measles, Mumps, Rubella: (a) Pre-Employment: Two (2) doses of MMR (measles-mumps-rubella) vaccine. Alternately, two (2) doses of live mumps-containing vaccine and one (1) dose of rubella vaccine ...OR	M 215	M 215 1-20-22 1-8) Corrective action includes the assignment of a designated individual, HR Specialist, ("HRS") to be responsible for the collection and audit of all required immunization documentation upon hiring. Effective Wednesday, January 19, 2022. a policy has been established whereby a new employee is only permitted to begin working on the floor once confirmation has been received by the HRS required documentation is complete.	

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M 215	Continued From page 4 (b) Laboratory evidence of immunity or laboratory confirmation of disease (i.e., laboratory report of positive IgG titers for measles, mumps and rubella). An equivocal laboratory result for measles, mumps and/or rubella are considered negative and vaccination is required ... 2. Varicella (Chickenpox): a. Two (2) doses of varicella vaccine. The second dose of varicella vaccine must be administered at least four (4) weeks after the first dose; OR b. Laboratory evidence of immunity or laboratory confirmation of disease; OR c. A healthcare provider diagnosis of varicella or healthcare provider verification of history of varicella disease; OR d. History of herpes zoster based on healthcare provider diagnosis. 3. Tetanus, Diphtheria, and Pertussis (Whooping Cough): a. Pre-employment: One (1) single dose of Tdap (tetanus-diphtheria-pertussis) vaccine is required for all health care workers who have not previously received a dose of Tdap vaccine ... 4. Annual Seasonal Influenza: a. Annual influenza vaccination is required for all health care workers as defined in §7.4, subject to 7.8 (H) when there is insufficient vaccine supply as determined by the Department. b. Each health care facility shall develop a	M 215	KL 1/31/22	

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M 215	Continued From page 5 specific plan to require annual influenza vaccination of all health care workers in a timely manner in keeping with ACIP guidelines, and at no cost to the health care worker. c. Each health care facility shall maintain an active surveillance program to track and record influenza vaccination levels among health care workers, including vaccinations obtained outside of the formal health care facility program ... 5. Tuberculosis (TB): (a) Pre-employment. Evidence that the health care worker is free of active tuberculosis based upon the results of a negative two-step tuberculin skin test shall be required. (1) If documented evidence is provided by the health care worker that a two-step tuberculin skin test, performed within the most recent twelve (12) months prior to hire, was negative, the requirements of this section shall be met. For health care workers who can present documentation of serial tuberculin testing with negative results in the prior two (2) years (or more), a single baseline negative tuberculin test is sufficient evidence of absence of TB infection. (2) A negative FDA-approved blood assay for Mycobacterium tuberculosis (BAMT) may be used instead of a two-step tuberculin skin test. If the baseline BAMT is positive, screening should proceed as indicated below for positive PPD. (3) Documentation shall include date and result of the tuberculin skin test (PPD), and reaction size in millimeters or an actual copy of the laboratory test result from a BAMT.	M 215	MLR 1/31/22	

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M 215	Continued From page 6 (4) If the PPD test or BAMT is positive, consistent with the most current Centers for Disease Control and Prevention {CDC} guidance, or a previous one is known to have been positive, a physician's or other licensed practitioner's (acting within his/her scope of practice) certification that the health care worker is free of active disease shall be required ... (5) A physician, certified registered nurse practitioner, or a physician assistant may certify that the health care worker is currently free of TB based on his/her clinical judgment for complex cases or unusual circumstances that do not fit the above criteria ... 6. Hepatitis B Vaccination and Testing: a. Health care facilities shall abide by the OSHA Blood Borne Pathogens Standard, incorporated above at § 7.3(E) of this Part including the offering of hepatitis B vaccination ... (c) Employees at risk of exposure to blood-borne pathogens shall be offered hepatitis B vaccine within ten (10) days of employment... (3) Persons failing to develop a titer shall be offered a repeat three (3) dose series with follow up titers. (4) Employees have the option of signing a standard OSHA declination form if they choose not to be vaccinated and should be counseled regarding risk..." 1) Record review for Nursing Assistant (NA) Staff F, revealed a hire date of 6/7/2021. The record failed to reveal evidence of the required vaccinations or titer for MMR, Varicella, Tdap,	M 215	1-2; 4-5) The orientation packet has been revised to specify where an individual may go to receive his or her Hepatitis B vaccination, and team responsible for conducting orientation have been in-serviced on the revised form. MR 1/31/22	

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M 215	Continued From page 7 and Influenza. The record also failed to reveal evidence of a two-step PPD, and that the employee was offered the Hepatitis B vaccination or had evidence of a completed Hepatitis B vaccination series, or a titer as required. 2) Record review for NA Staff A, revealed a hire date of 10/5/2021. The record failed to reveal evidence of a vaccination for Influenza. The record also failed to reveal evidence of a two-step PPD, and that the employee was offered the Hepatitis B vaccination or had evidence of a completed Hepatitis B vaccination series, or a titer as required. 3) Record review for NA Staff G, revealed a hire date of 11/19/2021. The record failed to reveal evidence of a vaccination for Influenza. The record also failed to reveal evidence of a two-step PPD as required. 4) Record review for Nurse Staff B, revealed a hire date of 10/15/2021. The record failed to reveal evidence that the employee was offered the Hepatitis B vaccination or had evidence of a completed Hepatitis B vaccination series, or a titer as required. 5) Record review for Nurse Staff C, revealed a hire date of 12/13/2021. The record failed to reveal evidence of the required vaccinations or titer for MMR. The record also failed to reveal evidence of a two-step PPD, and that the employee was offered the Hepatitis B vaccination or had evidence of a completed Hepatitis B vaccination series, or a titer as required. 6) Record review for NA Staff D, revealed a hire date of 10/5/2021. The record failed to reveal evidence of the required vaccinations or titer for	M 215	1-3; 5-8 A policy and procedure has been established effective January 17, 2022, whereby any PPD's performed in the Atrium will be scanned to the HRS rather than sent interoffice, and a copy retained in the Atrium building. Additionally, a binder has been created in which all new employees who are in the process of obtaining their PPD's by the Atrium team, will be tracked to ensure all are completed within the appropriate time frame.	

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M 215	Continued From page 8 Varicella and Influenza. The record also failed to reveal evidence of a two-step PPD as required. 7) Record review for NA Staff E, revealed a hire date of 10/15/2021. The record failed to reveal evidence of an Influenza vaccination. The record also failed to reveal evidence of a two-step PPD as required. 8) Record review for Nurse Staff H, revealed a hire date of 12/21/2021. The record failed to reveal evidence of a two-step PPD as required. During a surveyor interview with the Administrator on 12/29/2021 at 2:24 PM and on 12/30/2021 at approximately 1:15 PM, she was unable to provide evidence for the above required documentation.	M 215		
M 225	PERSONNEL 1.14.6.A. In-Service Education 1.14.6.A. An in-service educational program shall be conducted on an ongoing basis, which shall include an orientation program for new personnel and a program for the development and improvement of skills of all personnel. The in-service program shall be geared to the needs of the elderly, physically disabled, and individuals with dementia, and shall include annual programs on but not limited to: 1. Prevention and control of infection; 2. Food services and sanitation, 3. Emergency preparedness, fire prevention and safety; 4. Confidentiality of resident information; 5. Rights of residents, resident-directed care, and person-centered care; and 6. Any other area related to resident care or services routinely provided at the nursing.	M 225		

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M 225	Continued From page 9 a. Provision shall be made for written documentation of programs, including attendance. Flexible program schedules shall be formulated at least two (2) months in advance. b. In addition to any state or federal training requirements pertaining to long term care facilities, or training deemed appropriate by the nursing, each designated universal worker shall maintain a current certification as a Manager Certified in Food Safety pursuant to the rules and regulations for Certification of Managers in Food Safety (Part 50-10-2 of this Title). This Requirement is not met as evidenced by: Based on record review and staff interview it has been determined that the facility failed to provide an in-service educational program conducted on an ongoing basis, which shall include an orientation program for new personnel and a program for the development and improvement of skills of all personnel. The in-service program shall include an annual program including, but not limited to, food services and sanitation. Findings are as follows: Record review of the facility's yearly in-service training binder and new team member orientation folder failed to reveal evidence that training is provided in the required area of food services and sanitation. During an interview on 12/30/2021 at approximately 1:15 PM with the Administrator, Director of Nursing Services, and Staff I, they were unable to provide evidence that all personnel received in-service education upon hire or annually in food services and sanitation.	M 225	M 225 1-20-22 1. Effective Friday, January 21, information on food service and sanitation will be added to the new hire orientation and reviewed with all team upon hire and annually.	

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M 630	Continued From page 10	M 630		
M 630	RESIDENT CARE SERVICES 1.16.2.A. Infection Control 1.16.2.A. The nursing facility shall be responsible for no less than the following: 1. Establishing and maintaining a nursing facility -wide infection surveillance program; 2. Developing and implementing written policies and procedures for the surveillance, prevention, and control of infections in all resident care departments/services; 3. Establishing policies governing the admission and isolation of residents with known or suspected infectious diseases; 4. Developing, evaluating and revising on a continuing basis infection control policies, procedures and techniques for all appropriate areas of nursing facility operation and services; 5. Developing and implementing a system for evaluating and recording the occurrences of all infections relevant to employment (e.g., skin rash) among personnel and infections among residents; such records shall be made available to the licensing agency upon request; 6. Implementing a TB infection control program requiring risk assessment and development of a TB infection control plan; early identification, treatment and isolation of strongly suspected or confirmed infectious TB residents; effective engineering controls; an appropriate respiratory protection program; health care worker TB training, education, counseling and screening; and evaluation of the program's effectiveness, per guidelines in Recommendations for Preventing the Spread of Vancomycin Resistance. a. The TB infection control plan shall include, at a minimum, a provision that residents shall be screened for TB, within fourteen (14) days of	M 630		

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M 630	Continued From page 11 admission, and found to be free of active tuberculosis based upon the results of a negative two-step tuberculin skin test. If documented evidence is provided that the resident has had a two-step tuberculin skin test, performed within the most recent twelve (12) months prior to admission, that was negative, the requirements of this section shall be met. 7. Developing and implementing an institution-specific strategic plan for the prevention and control of vancomycin resistance, with a special focus on vancomycin-resistant enterococci, per guidelines in rules and regulations pertaining to Immunization, Testing, and Health Screening for Health Care Workers (Part 50-10-2 of this Title). (See also Guidelines for the Control of Vancomycin Resistant Enterococci (VRE) in Nursings and Extended Care Facilities for additional information on this issue). 8. Developing and implementing protocols for: 1) discharge planning to home that include full instruction to the family or caregivers regarding necessary infectious diseases which may present the risk of continuing transmission. Examples of such diseases include, but are not limited to, tuberculosis (TB), Methicillin resistant staphylococcus aureus (MRSA), vancomycin resistant enterococci (VRE), and clostridium difficile. 9. Assuring that all resident care staff are available in order to assist in the prevention and control of infectious diseases and are provided with adequate direction, training, staffing and facilities to perform all required infection surveillance, prevention and control functions. This Requirement is not met as evidenced by:	M 630	MLR 1/31/22	

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M 630	Continued From page 12 Based on surveyor observation, record review and staff interview it has been determined the facility failed to develop and implement written policies and procedures for the prevention and control of infections relative to urinary catheter care for 1 of 1 resident reviewed with a urinary catheter, Resident ID #4. Findings are as follows: Review of the facility's policy titled "Infection Control-Indwelling Catheter Care", failed to reveal evidence of policies and procedures for the prevention and control of infections related to the care of a urinary catheter bag or of its spout. Record review revealed the resident was readmitted to the facility in December of 2021 with diagnosis including, but not limited to, urinary retention (a condition in which you are unable to empty all of the urine from your bladder) and a urinary tract infection (UTI). Additional record review revealed the resident has an indwelling urinary catheter (a plastic or rubber tube that is inserted into the bladder to drain the urine and is emptied via a spout). During a surveyor observation of the resident on 12/28/2021 at approximately 11:45 AM revealed his/her urinary collection bag with the spout not secured to the bag and touching the floor. During an additional observation of the resident's catheter bag, in the presence of the Director of Nursing Services (DNS) on 12/28/2021 at approximately 12:45 PM, she acknowledged the urinary collection bag spout was touching the floor and indicated that she would expect staff to ensure that the spout was not touching the floor.	M 630 MK 1/31/22	M 630 1. Our policy and procedure has been amended to include "care of urinary catheter & its spout." on which all members of the Atrium nursing Team will be in-serviced by 2/5/2022.. Documentation of these in-services will be maintained and tracked.	1-20-22

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M 630	Continued From page 13 Additionally, during subsequent interviews with the DNS on 12/28/2021 at 2:05 PM and on 12/30/2021 at 10:45 AM, she acknowledged that the facility's policy did not contain procedures for the care and maintenance of catheter collection bags or for the collecting bag spout.	M 630		
M 665	RESIDENT CARE SERVICES 1.16.4.A. Resident Immunization Policies 1.16.4.A. Every nursing facility in Rhode Island shall request that residents be immunized for influenza virus and pneumococcal disease in accordance with R.I. Gen. Laws Chapter 23-17.19 This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to ensure that residents receive vaccinations in accordance with the Centers for Disease Control and Prevention (CDC) Advisory Committee on immunization practices standard relative to 2 of 5 residents reviewed, Resident ID #s 2 and 5. Findings are as follows: Record review of the CDC document titled "Vaccines and Preventable Disease: Pneumococcal Vaccination" states in part, "...CDC recommends routine pneumococcal polysaccharide vaccination for all adults 65 years or older..." 1. Record review revealed Resident ID #2 was admitted to the facility in October of 2021 with diagnoses which include, but are not limited to,	M 665 MLL 1/21/22	M 665 1-20-22 The Director of Nursing has conducted a chart audit to determine if any resident who has a signed consent for the PNA vaccine has received the vaccine. If received, documentation will be included in the EMR. Resident ID # 2 & resident ID # 5 will receive the PNA vaccine by 1/21/22 from our local pharmacy. This will be documented into the EMR. All new admissions who consent to a PNA vaccine will receive the vaccine in a timely manner.	

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M 665	Continued From page 14 chronic obstructive pulmonary disease (a group of lung diseases that block airflow and makes it difficult to breath) and pneumonia. Record review for Resident ID #2 revealed a document titled "Pneumococcal Immunization Informed Consent" dated 10/29/2021 which states in part, "...hereby give The Village at Waterman Lake permission to administer a pneumococcal vaccination..." Record review failed to reveal evidence that the above-mentioned vaccine was administered to the resident after the consent was signed. 2. Record review revealed Resident ID #5 was admitted to the facility in March of 2020 with diagnosis which include, but are not limited to, chronic obstructive pulmonary disease. Record review for Resident ID #5 revealed a document titled "Immunization Informed Consent: Pneumococcal" dated 3/4/2020 states in part, "...The Village at Waterman Lake has permission to administer a pneumococcal vaccination..." Record review failed to revealed evidence that the above-mentioned vaccine was administered to the resident after the consent was signed. During an interview with the Director of Nursing Services on 12/29/2021 at 1:40 PM and on 12/30/2021 at 10:15 AM, she acknowledged that the above-mentioned consent forms were signed to receive the pneumonia vaccine and she was unable to provide evidence that the residents had been administered the vaccination.	M 665	MR 1/21/22	

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M 865	Continued From page 15	M 865		
M 865	DIETETIC SERVICES 1.17.3.D. Dietetic Services 1.17.3.D. Adequate space, equipment and supplies shall be provided for the efficient, safe and sanitary receiving, storage, refrigeration, preparation and service of food and other related aspects of the food service operation in accordance with the Rhode Island Food Code (Part 50-10-1 of this Title). This Requirement is not met as evidenced by: Based on surveyor observation, record review, and staff interview it has been determined the facility failed to provide adequate storage and refrigeration preparation and other related aspects of the food service operation in accordance with the Rhode Island Food Code (Part 50-10-1 of this Title) for 1 of 1 medication carts observed and 1 of 2 kitchenette refrigerators observed. Findings are as follows: Review of the document titled, "Supplement to the 2017 Food Code U.S. Public Health Service FDA U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES", states in part, "...Temperature and Time Control...temperature shall be held: (A) Under refrigeration that maintains the FOOD temperature at 5°C [5 degrees Celsius] (41°F) [41 degrees Fahrenheit] or less..." Review of the document titled, "Food Safety Plan Elements", published by the Rhode Island Department of Health, Center for Food Protection, last updated in September of 2021 states in part:	M 865	M 865 1-20-22 1) A work order is on file for the repair of the Atrium refrigerator. The coil needs to be placed per the work order. Awaiting the repair. The Atrium was given a replacement refrigerator on 12/28/21. Temperatures have been taken with accurate readings as of this date.	

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M 865	Continued From page 16 "...c. Cold Holding: Each piece of refrigeration equipment used to hold TCS [time/Temperature Control for Safety foods] will be provided with a thermometer to record the ambient temperature at the warmest portion of the equipment. A temperature-monitoring log will be placed on the exterior door of each piece of refrigeration equipment...The manager responsible for opening the kitchen will check the thermometer in each piece of refrigeration equipment at start of the workday and record the temperature on the log. The manager responsible for closing the establishment is responsible for recording the ambient temperature of each refrigeration unit before leaving for the evening...The closing manager will verify that ready to eat TCS foods held for more than 24 hours are properly date-marked as required. Ambient temperatures above 41°F [Fahrenheit] require corrective action..." During a surveyor observation on 12/28/2021 at approximately 11:55 AM of a form displayed on the front of the kitchenette refrigerator titled, "Refrigerator/Freezer Temperature Log" states in part, "...Record refrigerator/freezer temperature Refrigerator 36-39 degrees F...action column is to indicate steps taken if temperatures are not in compliance...initial eat [sic] recording...", revealed the following: 12/26/2021 47 degrees F at 8 AM 48 degrees F at 12 Noon 46 degrees F at 5 PM 12/27/2021 46 degrees F (no time indicated) 46 degrees F (no time indicated)	M 865 MP 1/31/22		

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M 865	Continued From page 17 48 degrees F (no time indicated) 12/28/2021 45 degrees F (no time indicated) 47 degrees F (no time indicated) 47 degrees F (no time indicated) Further review of this document revealed the above mentioned temperatures were initialed by Dietary Staff J, and the "action" column was blank for all dates. During a surveyor interview with Staff J, on 12/28/2021 at 11:56 AM, he revealed the refrigerator has been "broken for a couple of months now". During a surveyor observation on 12/28/2021 at 11:54 AM, in the presence of the Director of Nursing Services (DNS), revealed a thermometer, located inside of the refrigerator, which was observed at 50 degrees F. During a subsequent observation of the kitchenette refrigerator in the presence of the Food Service Director (FSD), on 12/28/2021 at 12:02 PM, he acknowledged the thermometer read 50 degrees F. 2. During surveyor observation of the kitchenette refrigerator on 12/28/2021 at approximately 11:50 AM, revealed one-32 oz.(ounce) Sysco Med Plus 2.0 butter pecan high calorie high protein nutritional drink carton opened and not dated. Manufacturer label states in part, "Storage and handling refrigerate after opening and use within 3 days." During a surveyor interview with the DNS on 12/28/2021 at approximately 11:54 AM, she	M 865		

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M 865	Continued From page 18 acknowledged the above mentioned nutritional drink was opened and not dated according to manufacturer instructions. A subsequent observation of the kitchenette refrigerator in the presence of the FSD on 12/28/2021 at 12:02 PM, revealed one-32 oz. Sysco Imperial Med Plus 2.0 natural oat flour high calorie high protein nutritional drink opened and not dated. Manufacturer label states in part, "Storage and handling refrigerate after opening and use within 3 days". During an interview immediately following this observation with the FSD, he indicated that the container should have been dated when opened. 3. During a surveyor observation of the medication cart on 12/28/2021 at 2:08 PM in the presence of Nurse Staff K, one bottle of ProSource no carb collagen & whey protein formular 15 grams of protein, 60 calories supplement observed opened and not dated. Manufacturer instructions states in part "...Discard three months after opening..." During an interview immediately following this observation with Staff K, she acknowledged that the above mentioned supplement was opened, in use, and not dated. Additionally, she indicated that the supplement should have been dated when open. During an interview with the DNS on 12/29/2021 at 1:37 PM, she indicated that she would expect the supplements to have been dated when opened.	M 865	2 & 3). All Team working on the Atrium unit will be in-serviced on the procedure for labeling, dating and storing supplements and other pertinent aspects of the "Food Safety Plan Elements" by 2/5/22. WR 1/31/22	

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M 940	Continued From page 19	M 940		
M 940	PHARMACEUTICAL SERVICES 1.17.4.C. Pharmaceutical Services 1.17.4.C. Adequate space, equipment, supplies and locked storage areas shall be provided for the storage of drugs and biologicals based on the scope of services provided. Refrigerated food storage units shall not be utilized for storage of drugs and/or biologicals except: This Requirement is not met as evidenced by: Based on surveyor observation and staff interview, it has been determined that the facility failed to store drugs and biologicals in a locked storage area for 1 of 1 medication cart observed. Findings are as follows: Review of the facility policy dated 8/1/2017 titled "Medication Cart" states in part "...Medication cart is not to be left unattended when in a resident's room giving medications, the cart is to be within the nurse's sight or locked..." Surveyor observation on 12/28/2021 from 12:29 PM to 12:38 PM, the medication cart was observed unlocked in the resident common area without staff in sight for approximately 9 minutes. During a surveyor interview immediately following this observation with Nurse Staff K, she acknowledged that the medication cart was unlocked and not in view of the staff. She indicated that the medication cart should have been locked. During an interview on 12/29/2021 at 11:01 AM with the Director of Nursing Services, she indicated that she would expect the medication	M 940	M 940 1-20-22 The Director of Nursing will conduct an in-service with all relevant team on the Atrium's "Medication Cart" policy. This will be completed by 2-5-22. MK 1/31/22	

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M 940	Continued From page 20 cart to be locked when not in use and when not in view of the staff.	M 940		
M1295	PHYSICAL PLANT 1.19.4.A. Emergency Power 1.19.4.A. An emergency electrical system shall be provided and installed in accordance with the applicable requirements as specified in the NFPA 99, 2012 Edition. The source of supply shall be an on-site fuel-fired generator. 1. Such emergency power system shall supply power adequate at least for: a. Lighting all means of egress; b. Equipment to maintain fire detection, alarm and extinguishing systems; c. Life support systems, where applicable or of high probability of need to ensure an emergency response to health and safety; and d. Continuation of normal health and safety operations of the nursing facility until normal operations resume or implementation of the ' s EOP plan and safe evacuation of all residents. 2. The nursing facility is responsible for ensuring appropriate testing and preventive maintenance of the generator in accordance with the NFPA 99, 2012 Edition and NFPA 110. 2010 Edition, including: a. Generator is maintained and serviced in accordance with its manufacturer ' s requirements; b. Generator is inspected weekly and exercised (tested) under routine operational load for thirty (30) minutes each month. c. In addition to its own internal resources, each nursing facility shall also have agreements with contracted service providers for emergency services, should the generator fail during testing or unscheduled use. d. The nursing facility will maintain documentation	M1295		

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M1295	Continued From page 21 of all testing and preventive maintenance of the generator system, and e. The nursing facility will notify the licensing agency when the system is or is expected to be off-line for more than eight (8) hours for maintenance or when there is a significant failure of the equipment during testing or unscheduled use, or an inability of the equipment to provide for fifty (50) per cent of the operational load at any time of its operation. This Requirement is not met as evidenced by: Based on record review and staff interview it has been determined that the facility failed to ensure appropriate testing of the generator in accordance with the NFPA 99, 2012 Edition and NFPA 110, 2010 Edition, including ensuring the generator is inspected weekly and exercised (tested) under routine operational load for thirty (30) minutes each month. Findings are as follows: Record review of the facility document titled "Generator Load Test Logs 2020-2021" failed to reveal evidence that the facility conducted the monthly 30-minute generator load testing in April, June, October, November, and December of 2021. During an interview with the Administrator on 12/30/2021 at 10:55 AM, she acknowledged the monthly generator testing was not completed for the above noted dates. Additionally, she was unable to provided evidence that the generator was inspected weekly by the facility as required.	M1295	M 1245 1-20-22 We have instituted a system whereby specific individuals are designated to complete monthly generator checks, which are logged and maintained. In addition, our monthly maintenance log will be updated to include a weekly generator check by our building's maintenance technician, as a superfluous tracking mechanism. This will go onto effect February 1, 2022. 1/21/22	